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ABSTRACT

Approximately 50% of American marriages have some sexual dysfunction. Because sexuality is an important part of a person's life, counselors should be sensitive to sexual concerns of their clients. Taking an adequate sex history and highlighting problem areas may increase counseling efficiency. When counselors teach courses on human sexuality, they may note an increase in the number of subsequent clients presenting sexual problems. School counselors who provide an atmosphere conducive to sharing and exploration will have students seek them out for counseling about sexual matters. Several case studies are described which focus on typical presenting problems: dyspareunia, difficulty in becoming pregnant, homosexuality, impotency and orgasmic concerns. Additionally, a listing is included which suggests some of these symptoms of sexual abuse to which counselors should be sensitive. (Author/NRB)

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SEXUAL PROBLEMS OF COUNSELEES

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Estimates of sexual dysfunction with marriage continue to be in the area of 50% (McCary). A more recent estimate limited this to 50% of happy marriages (Maultsby & Carpenter) with no estimate for unhappy marriages or for the amount of dysfunction in all marriages. While the earlier estimate that one-half of all marriages experience some sexual dysfunction is alarming, it is much more alarming to think that half of the "happy" marriages are experiencing some form of sexual dysfunction. Actually, this lends support to the accusation that sex education is virtually ignored by the schools, home, and church, and that most of the population is lacking in factual information about sexuality (McCary).

Dr. Masters states that he believed that a minimum of 60% of all sexual dysfunction could be corrected by accurate instruction in sexuality. Some other estimates of the corrective value of basic sex information go as high as 80% of the cases of sexual dysfunction.

When a course is intiated in human sexuality, the interest is immediately obvious. Not only will the course be a popular one but the instructors will notice that their clients appear to be presenting more problems in the area of sexuality than prior to the teaching of such a course. Sexuality is an important part of an individual's life, and it is necessary for the counselor or therapist to be sensitive to concerns or problems in this area. Perhaps the teaching of such a course sensitizes the counselor to sexual concerns of counselees. Another possible explanation is that the teaching of a course on sexuality makes you the visible authority on such matters and you are perceived as more knowledgeable and/or more approachable about sexual matters.

While we do not want to make each person who walks into our

offices a sexual cripple, we do need to provide the atmosphere (a la Rogers) which will allow the client the freedom to discuss very sensitive matters with us. There are perhaps three types of clients who will come to you as a result of teaching a course in sexuality. There are those people who have concerns about their sexuality, some need good basic information, and some are referred by friends or relatives. Within the courses of psychology are many students who take the course out of curiosity as well as many who come seeking a solution to conscious or unconscious problems. Psychosexual Adjustment is no exception.

Perhaps the best method of illustrating the thesis that teaching a course on sexuality will increase the number of counselees presenting problems of a sexual nature is by reporting some typical case examples.

1). Dyspareunia

A female student, 21 years old, who had been married less that four months came complaining of severe pain when intercourse was attempted. Her physician had diagnosed her condition as endometriosis and had painted a rather gloomy picture of her future. First, he stated she might be sterile as the result of the endometriosis. Second, he said it might be necessary for her to attempt getting pregnant at once if the couple ever wanted to have children. Last, since intercourse was painful he suggested they skip it for weeks or maybe months unless pregnancy was desired. Needless to say, she was frightened and felt very little support for her situation. Basically, relaxation techniques were suggested plus a change in "missionary" position of male superior which allowed little control of the female in the matters of thrusting. It was suggested that one of two positions often recommended for the later stages of pregnancy be tried, i.e., a side position with male behind or the "T" position. The side position with the male behind proved to be satisfactory. It allowed

intercourse to take place and eliminated the pain. The female superior position would have been another possibility because of the control it gives the female. However, in this case it was not as satisfactory as the other two positions. In a brief session one afternoon I explained the suggested positions. The next day as I saw the student coming down the hall of the classroom building I did not need a verbal report - her face told me my suggestion had worked. Her response was, "why didn't my doctor tell that?" The medical problem was gradually resolved but it was not necessary or advisable for intercourse to be delayed until the endometriosis was eliminated.

2). Inability to get pregnant

A call from a former student one afternoon indicated need for a counseling session as soon as possible. An appointment was made for the last of the week. The subject, a 25 year-old female school teacher, came in and appeared to be extremely tense. She related a tale of over four years of procedures and numerous techniques. None of which had enabled her to become pregnant. In addition to thousands of dollars spent, some of the procedures had been physically painful. After about an hour I stated that this experience had been a bad scene and I thought getting pregnant should be fun. Through her tears she acknowledged that sex had become a chore with no pleasure involved. I gave her a 30 minute deep muscle relaxation tape and told her to quit having sex on schedule. She agreed to start the relaxation exercises and to engage in intercourse only when she and her husband genuinely wanted to do so. A short vacation had been planned to begin about two weeks from the day of her visit. So I told her to leave her books at home along with her thermometers and go have a good time. We agreed to talk by telephone and she was to start coming on a weekly basis after her school year was over. Six

weeks later, she called to say the doctor had just confirmed she was definitely pregnant. The pregnancy went well. All this client needed was to relax. She and her husband were so tense until pregnancy was virtually impossible.

3). Homosexuality

A male student about 22 years of age was referred to me because of depression and suicidal thoughts. He related a tale of nightmares, frustrations, and fears. He had become convinced he was homosexual because when he showered or dried off he would often experience an erection. He had become almost phobic about attempts to avoid touching his genitals. He was afraid to ask his father about this because he was convinced these reactions proved he was homosexual and he was sure this information would be devastating to his father. Several short sessions of information sharing about sexuality were begun. The student was given printed material to take home and read between visits. He made weekly visits for a period of two or three months. He took a job in another city and I did not hear from him directly for almost a year. A recent call one night was an affirmation that he developed a more healthy view of his sexuality, and he feels he is well adjusted.

4). Newlyweds

A male about 20 years of age approached me after class and stated he could not "stand it anymore." He said he had been married for about four months and his wife felt sex every two weeks was often enough. I responded that I thought this was "slightly below average" and made an appointment for the couple. This was a very naive couple who had both been virgins at marriage. It appeared the wife had more erroneous ideas about sex than the husband. In addition to a heavy work and study schedule, they spent every weekend with one set of parents or the other. Some frank discussions about planning for sex and looking at the barriers they had set up to avoid sex resulted in a much

improved relationship. Follow up indicated a satisfactory adjustment.

5). Impotency

A male, 45 years of age, mentioned to me following a class that he was experiencing some failure in maintaining an erection. An appointment was made for him. After discussions with him it was decided to involve his wife. Joint sessions with the couple in which several issues were discussed and reading material was given for use between sessions led to the introduction of a modification of Masters and Johnson's Sensate Focusing Technique. Again, misconception had led to the beginning of a marriage crisis. Follow up indicates good marital adjustment one year later.

6). Non-orgasmia

A young woman about 23 came to my office because she was unable to achieve an orgasm. She had divorced her husband about two years earlier because she was non-orgasmic. She stated that although she "thought" she loved him, obviously she did not or she would have been able to achieve an orgasm. She was presently involved with a man who had asked her to marry him. She described the relationship as one that was very satisfying except for the lack of orgasmic response. My comment was "the rockets have not gone off and the band marched across the field." She stared at me and confirmed what I had said. Her reading of "Hollywood" literature had convinced her that when orgasm occurred she would literally see stars, rockets and hear bands playing. The physiology of the orgasmic response was covered and some reading material was given to her. Follow-up at six months indicated satisfaction resolution. She was orgasmic and recognized it as such.

Taking an adequate sex history and highlighting problem areas will increase the efficiency of your counseling. Sex histories can be taken using a medical model or form or can be more unstructured such as the sex history taken by

Masters and Johnson. If you are knowledgeable about sexuality and open to discussions bearing on sexuality, I believe a majority of your clients will present problems of a sexual nature.

In the school setting the couselor should be particularly aware of students suffering from sexual abuse. Some of the more often encounter symptoms include:

1. Truancy and/or persistent running away behavior
2. Chemical abuse
3. Depression
4. Drop in school performance
5. Low or poor self-concept which maybe reflected in inappropriate clothing, lack of cleanliness, poor hygiene habits
6. Little or no involvement in school activities through self-choice or very restrictive demands on the part of the family
7. Few school friends - appears withdrawn or isolated
8. Recurrent somatic complaints, i.e., headaches, stomachaches, etc.
9. Physical abuse - particularly self-inflicted
10. Overly seductive behavior
11. Promiscuous sexual behavior
12. Heavy home or child care responsibilities

Among young children either elementary age or pre-schoolers one should be alerted by such signs as:

1. Open sexual behavior
2. Clinging or whining after a particular parent (non-abusive)
3. Nightmares, severe or reoccurring
4. Regression in development
5. Excessive masturbating behavior

6. Inappropriate lack of control of bowels and/or bladder for age

7. Knowledge of sex acts that show explicit details of terminology

Sexual abuse maybe as prevalent as physical abuse and it is much more difficult to document and prosecute. The counselor who provides the atmosphere conducive to sharing and the opportunity for exploration will find many of the students in the public schools in need of counseling about sexual matters.

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